Authority

Federal: Title XXI of the Social Security Act, Public Law 89-97, as amended
State: Title 32.1, Chapter 13, *Code of Virginia*

Establishment of the National Children's Health Insurance Program

The Balanced Budget Act of 1997 established the Children's Health Insurance Program (CHIP) under Title XXI of the *Social Security Act*. The program, which is voluntary, became effective on October 1, 1997. Under it, states may extend health insurance coverage to uninsured children under age 19 living in families with incomes below 200 percent of the federal poverty line who are not eligible for Medicaid. Three options are available to states for increasing coverage under CHIP: expand Medicaid, establish a new insurance program separate from Medicaid, or implement a combination of both. States must supply matching funds, but the required matching rates are lower than for the Medicaid program.

The program attempts to improve children's access to health care by covering some of the 11.3 million children under age 19 that were estimated to be uninsured as of 1997. An analysis by The Commonwealth Fund based on the March 1997 *Current Population Survey* estimated that nearly half of all uninsured children--5.1 million-were eligible for Medicaid based on their poverty status and age. Another 4 million could become eligible under CHIP, including approximately 1.1 million children ages 14 through 18 who will become eligible for Medicaid with planned expansions over the following four years. Together, the programs held the potential of covering eight out of 10 uninsured children under age 19.

By September 1999, all 50 states, the District of Columbia and five U.S. territories had adopted CHIP programs and received the necessary approvals from the Health Care Financing Administration (HCFA). Two-thirds of the states used the increased flexibility to explore alternatives to Medicaid and created or expanded non-Medicaid programs. Of the 51 original CHIP plans set forth by each state and the District of Columbia, 18 expanded Medicaid, 17 created programs separate from Medicaid, and 16 implemented combination programs.

Establishment of the Virginia Child Health Insurance Program

Chapter 464 of the 1998 Virginia Acts of Assembly authorized the establishment of Virginia's Child Health Insurance Program known as the Children's Medical Security Insurance Plan (CMSIP) and directed the Department of Medical Assistance Services (DMAS) to promulgate regulations to implement the program to be effective July 1, 1998. Some 63,200 children were projected to be enrolled in the program when it reached maturity. Virginia submitted its plan for a separate program, CMSIP, to HCFA for approval on June 12, 1998. The CMSIP program was described as a separate program, but a Medicaid look-alike program. HCFA approved the plan on October 22, 1998.

Establishment of the Virginia Child Health Insurance Program (Continued)

In 2000, the General Assembly made changes in CMSIP to create the Family Access to Medical Insurance Security (FAMIS) program, which changed not only the name of the program but also changed the program from a Medicaid look-alike to a program modeled after the private sector. A revised Title XXI plan was submitted and approved by HCFA on December 22, 2000. Effective August 1, 2001, a separate application for FAMIS was implemented and a central processing unit CPU) with a call center was established for receipt and processing of FAMIS applications only. The income eligibility was simplified by raising the income limit to 200% of the Federal Poverty Level and gross income was used in the financial calculation. A new benefit package was introduced along with premiums and co-payments. The Employer Sponsored Health Insurance (ESHI) premium assistance component of the program was implemented. The Title XXI program's association with local departments of social services and Medicaid was severed.

In 2002, due to low enrollment in the Title XXI program and the difficulty families experienced navigating two different programs, the General Assembly directed DMAS to revise the program to facilitate enrollment. Effective September 1, 2002, the State began operating a combination Title XXI program, a Medicaid expansion as well as a separate program. Medicaid eligibility was expanded to 133% of the Federal Poverty Level for children 6-19 and FAMIS began covering children with gross family income in excess of 133% but less than or equal to 200% of the Federal Poverty Level. A combined application for Children's Health Insurance was developed and a "no wrong door" policy was implemented. Applications for Children's Health Insurance are accepted at the local departments of social services in the city of county where the child resides as well as the FAMIS CPU. Verification requirements for both Medicaid and FAMIS were streamlined, and to the extent possible, made uniform. In addition, monthly premium payments were suspended and, subsequently, were deleted from the FAMIS program requirements.

The 2003 General Assembly mandated changes were implemented on August 1, 2003. 1) The new program name for children enrolled in medically indigent Medicaid, “FAMIS Plus,” was introduced as part of the Children’s Health Insurance umbrella program that consists of FAMIS and children’s Medicaid, 2) FAMIS eligibility is continued for 12 months and will be canceled before the annual renewal only if a child turns age 19, a child moves out of Virginia, the family’s income increases to an amount that is over 200% FPL, or the DMAS insurance card is returned by the Post Office and the family cannot be located; 3) the FAMIS 6-month “waiting period” for children whose private health insurance was canceled was changed to 4 months; and 4) four community mental health services were added to the FAMIS benefit package - Intensive In Home for Children/Adolescents, Crisis Intervention-Mental Health, Case Management, Targeted Mental Health, and Day Treatment for Children.

Enrollment of eligible children in the Title XXI program continued to grow at a significantly increased rate following program improvements. By June 30, 2004 enrollment in the separate FAMIS program exceeded 37,000 and enrollment in the CHIP expansion of Medicaid was over 21,000 for a total CHIP population in excess of 58,000 children. In addition to continuing to refine program procedures and conduct an aggressive outreach campaign, efforts were focused on retaining eligible children and reducing the number who drop off each month while still eligible. DMAS made improvements to the annual renewal process at the FAMIS CPU and awarded grants to 14 local Departments of Social Services in October 2003 to test innovative and cost-effective strategies to improve retention. Best practices identified by the grantees will be considered for statewide implementation.

Eligibility for the Program

Children may be eligible for FAMIS if:

- They are ages 0 through 18,
- They are residents of Virginia,
- They meet the citizenship/alienage requirement,
- They live in families with gross income at or below 200% of the Federal Poverty Level,
- They are uninsured or have not had private health insurance for the past four months (some exceptions apply),
- They are not eligible for Medicaid,
- Their parents are not employed by a public agency with access to State Employee Health Insurance.

Services Covered by FAMIS

Children enrolled in FAMIS receive a comprehensive set of medical and dental benefits, including:

- Hospital Care
- Outpatient Care
- Physician Services
- Surgical Services

Services Covered by FAMIS (Continued)

- Outpatient and Community-Based Mental Health Services
- Inpatient Mental Health Services in a psychiatric unit of a general acute care hospital
- Laboratory and Radiological Services
- Prescription Drugs
- Home and Community-Based Health Services
- Clinic Services
- Dental Care Services
- Prenatal Care Pre-Pregnancy Family Services
- Ambulance Services
- Services for Special Education Students
- Hospital Emergency Services
- Durable Medical Supplies and Equipment
- Vision Care
- Abortion Services (only if necessary to save the life of the mother)
- Well-Child Care
- Rehabilitation Services
- Transplantation Services
- Hospice Services
- Nursing Services
- Early Intervention Services

Examples of Services Not Covered by FAMIS

Services not covered by FAMIS include:

- Inpatient Psychiatric or Psychological Services in a free-standing psychiatric hospital
- Friday or Saturday hospital admissions for non-emergency reasons or admission for more than one day prior to surgery unless the admission on those days is pre-authorized
- Weight loss clinic programs
- Telephone consultation
- Hospital charges and inpatient physician services for days of care not authorized for coverage
- Abortions, unless necessary to save the life of the mother
- Sterilization
- Medical care received from providers not authorized by DMAS or who will not accept payment from DMAS as payment in full

Eligibility Determination

Eligibility is determined by the FAMIS central processing site and the local departments of social services located throughout the Commonwealth. The FAMIS central processing site handles ongoing case management for FAMIS recipients. Applicants become eligible for the program on the first day of the month in which the application was received if the applicant met all eligibility factors in that month. Effective 08-01-03, enrollment is for 12 continuous months, unless one of the following events occurs before the annual renewal: 1) an increase in gross monthly to above 200% FPL, 2) a child moves out of state, 3) a child turns age 19, 4) the family requests cancellation, or 5) the family applies for Medicaid for all the children and they are determined are determined eligible for Medicaid. Families must report the following changes before the annual renewal: 1) an increase in gross monthly income only if it goes above 200% FPL, 2) a child moving out of the home, 3) any address change, and 4) applying for a new child in the home. Eligibility is renewed annually.

Providers and Provider Reimbursement

Services are delivered through HMOs under contract with DMAS in areas of the Commonwealth where FAMIS HMOs exist and through providers who are reimbursed on a fee-for-service basis in other areas of the State. Reimbursement is largely based upon rates established for the Commonwealth's Title XIX Program. Reimbursement differs from Medicaid in the following respects:

- Payments made for inpatient hospital services, outpatient hospital services, Federally Qualified Health Center and Rural Health Center services, inpatient mental health services, outpatient rehabilitation services, and outpatient substance abuse services are final. There are no retrospective cost settlements.
- Reimbursement for inpatient hospital services and inpatient mental health services does not include payments for disproportionate share or gradate medical education made to hospitals.

Program Data and Statistics

Statistics on enrollment in the program and payments made for services provided to recipients are shown in the following pages.